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CHAPTER X

WELFARE: HEALTH AND EDUCATION

1. Health and Progress

Good health is a condition of both human welfare and economic progress. Most people would agree that, if there is one sphere of human life in which the West can promote greater material welfare in the tropics, it is in the conquest of disease. For whereas western medicine rests on modern science and, by applying reason to the cure and prevention of disease, daily performs new miracles, the native medicine of the tropics is pre-scientific. Its practitioners inherit a traditional knowledge of herbs and rules of healing, and probably acquire some skill from clinical experience; even in Africa not all those who practise native medicine can be dismissed as witch-doctors,[1] but native medical practice is empirical, and its sovereign remedy is faith. Not infrequently it cures where western science fails because western medicine still calls, as it has always done, for faith, and the people trust their own doctors rather than Europeans. But if medical treatment in the tropics is to reach a higher standard, the empirical methods of native practitioners must be corrected, supplemented or replaced by methods based on scientific principles. This is the more urgent because economic development, unless kept under control, fosters unhealthy conditions, spreads disease and makes for the deterioration of native medical practice.

Doubtless under native rule the standard of health varied greatly from one place to another according to the climate, soil and native social customs, and the good physique and healthiness of tropical peoples have often attracted favourable comment. In Burma Europeans have been puzzled to reconcile the sparse population with the robust constitution of the Burmese. In Malaya 'the general good health and freedom from tuberculosis'[2] have been attributed to the fact that the villagers usually choose a site where air, light and water are abundant and build their houses in a manner that ensures good ventilation. In Africa 'early European travellers speak of the magnificent physique of the Ngoni warriors and their amazing feats of endurance'.[3] Economic development changes the environment.

[1] *African Survey*, p. 1198. [2] Mills, p. 320. [3] Read, p. 21.

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titioners and patients do not know the difference and buy the cheapest.[1]

These probably are among the chief reasons why 'the systems of oriental medicine have fallen into decay'. The task of improving the standard of health in the tropics is aggravated by the fact that western medical science usually reaches the people as one aspect of economic penetration, and must first be applied towards repairing and preventing the mischief naturally consequent on the process of development. A solution of the problem has been attempted along two lines: the provision of medical assistance; and the introduction of modern hygiene. It is important to notice the essential difference between these alternatives. Medical assistance aims to promote *individual* welfare, and ordinarily requires the voluntary co-operation of the patient; hygiene aims to promote *social* welfare, and necessarily involves a certain measure of compulsion.

2. MEDICINE

Ordinarily the introduction of western medicine in the tropics originates in the needs of Europeans. From very early days the East India Company arranged with the Apothecaries Company for the supply of barber-surgeons to their ships and settlements. In Africa likewise the various administrations at first confined the provision of medical services to the needs of their own establishments. But administrative establishments are partly native, and non-officials in commerce and industry require medical attention. In Burma the earliest members of the general public to receive the benefits of western medical skill were the convicts in jail, and the expansion of medical services in the interior has been closely bound up with the growth of crime. It is only natural that generally throughout the tropics the provision of medical assistance has developed with the economic demand for doctors, and has been organized so as to cost no more than necessary.

But the spread of western medicine in the tropics has not been due solely to the growing demand for doctors; it has been due in part to the demand for patients. Medical missionaries look for patients. It is true that missionary organizations need doctors to preserve the lives of missionaries. But they have also recognized in western medicine an instrument for extending their influence among the people. To deliver their message they must find some method of

[1] *RPI* (India), 1897–1902, p. 245; *CISM*, pp. 13, 15, 23.

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things required for their examinations than to inspire them with professional traditions.

Medical science, then, serves to further economic progress rather than to promote native welfare. Economy forbids that Government shall spend more on medical assistance than will meet the demand at the least expense, and the demand is limited even more closely by economic factors. Employers who recognize that sickness involves a costly waste of labour can provide medical assistance,[1] and can insist as a condition of employment that their employees shall accept it. Personal interest in the well-being of their staff often induces them to press this doctrine to its farthest limits, but they must submit to the test of annual accounts to shareholders, and they cannot sacrifice efficiency to welfare without risking the loss of business to their competitors. Although missionaries can take more altruistic views, they find most scope for their activities in providing Government and western enterprise with medical facilities for their employees, and Christianity is enlisted in the cause of commerce.

It is not the case, therefore, that economic development is necessary as a condition of providing funds for medical services to the people, but medical services are necessary as a condition of economic development. The progress of medical science *as an instrument of welfare* depends on the organization of a demand for it among the people. How far tropical peoples voluntarily avail themselves of western medical assistance is uncertain; in Burma, as in Africa, they are readier to believe in western surgery which shows results than in western medicine of which the results are slower and less obvious. In general, western medical science has found little favour.[2] Burmans, we are told, 'don't care for English medicine'. In Siam western medicine has been encouraged since 1880, by their own King and not by foreign rulers, but 'in 1939 the old style doctor was still the one to whom the people ordinarily turn in times of sickness'. In Java, where natives have been trained to practise western medicine for nearly a hundred years, the people still have greater confidence in their own system, and in the general hospitals 40 % of the beds are empty because the people do not realize the benefits of western medicine.

[1] *African Survey*, p. 1194.

[2] *CISM*, pp. 1, 22; Leeuw, H. de, *Cross Roads of the Java Sea* (1931), p. 109. Fischer, Dr I. A., *Bulletin*, Colonial Institute, Amsterdam, 1939, p. 24; Landon, p. 114; *Rural Hygiene in Indo-China* (1937), pp. 11, 50.

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The usual explanation of the general reluctance to accept medical science is ignorance and conservatism. Yet the people readily accept new remedies that they find helpful. They are easily convinced, for example, of the value of quinine, and, as just noticed, will buy cheap imitations that are ineffective. Still more striking is the rapid spread of the new treatment of yaws and venereal diseases by injections.[1] These give speedy and obvious results, and quacks find ready patronage for cheap courses, long enough to cure the symptoms, if not to restore health. We have noticed that Burmans were quick to adopt inoculation as a prophylactic against smallpox, but slow to accept vaccination because inoculation gave results, and vaccination, administered by Indian subordinates with defective lymph, was not infrequently a failure. Natives will not admit the superiority of western medicine unless it effects cures where their own doctors fail, and they often find greater benefit from native treatment.[2] Modern science is no substitute for sympathy and understanding. A French doctor in Indo-China, who accompanied his treatment by tattooing his patients with charms in iodine, is said to have had great success.[3] But ordinarily western medicine is presented to the people as part of the apparatus of foreign rule and western enterprise. In Burma until recently the subordinate medical staff was almost wholly Indian, and the patients in small up-country hospitals were mostly sent there by the police. Yet it was possible to find Indian doctors with a gift of sympathy, whose hospitals, despite the barrier of race and language, were continually overcrowded with voluntary patients. But that was exceptional. The people generally do not want western medicine because they have no faith in it. Economic development multiplies the number of hospitals and doctors, but so far as their only patients are those required by administrative or estate rules to submit to western treatment, they have no bearing on welfare; they merely serve efficiency. If western medicine is to be an instrument of welfare, the people must be induced to want it. It is not enough for them to want it; there must be an economic demand for it. Very few can afford to pay the fees necessary to recompense a western practitioner for his long and costly training. So long as the people do not want and cannot afford western medical attention, the supply of hospitals and doctors is conditioned and limited by the demand arising out of the need for greater efficiency in business and administration.

[1] Mills, p. 315; *African Survey*, p. 1145; Landon, pp. 123, 125, 127.
[2] Teeling, pp. 19–21. [3] Thompson, V., *French Indo-China* (1937), p. 283.

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757 This hinders the progress of medical science and therefore hinders economic progress. To popularize western medicine 'it is not enough to multiply facilities (however good in themselves) for the treatment of such as apply for relief'.[1] In homogeneous western societies the improvement of medical facilities is a problem of supply; the demand for better medical care is almost unlimited, and the extension of medical relief depends upon the provision of larger funds and a better organization for meeting the demand. But in the plural society of the tropics the problem is one of demand; it is a waste of money to provide medical assistance for which there is no demand. Apart from compulsion, it is first necessary to organize the demand. That is a difficult matter. The appreciation of western medicine, as of co-operative principles, must ordinarily spread slowly, but disease, like debt, spreads daily. The machinery of co-operative credit without the spirit has proved useless or worse than useless, but the machinery of medical attention may seem to offer more scope for compulsion. Tropical diseases are a mass affliction, and their rapid elimination is necessary both to native welfare and to economic progress. Hence it is argued that the treatment 'to be effective must partake to some extent the character of an operation, scientifically planned and humanly conducted, but military in its spirit and in the thoroughness with which it establishes itself in the area which it has occupied'. Thus the provision of medical assistance tends to be transformed from the promotion of *individual* welfare, requiring voluntary co-operation, into the promotion of *social* welfare by compulsion, the method which is characteristic of hygiene.

3. Hygiene

744 Even in Europe it was only during the last half of the nineteenth century that men came to regard the state as responsible for public health and for the prevention of disease, and a growing volume of welfare legislation marked the earlier stages of the transition from a policy of *laissez-faire* to one of efficiency and social justice. The new trend of opinion naturally reacted on colonial policy. In India, although the growth of towns consequent on the development of trade had long compelled attention to conservancy, sanitation was not treated seriously until 1863, when a Royal Commission showed that the insanitary condition of urban areas was intimately connected with ill-

[1] *African Survey*, pp. 1115, 1196; *Social Policy in Dependent Territories* (1944), p. 6.